LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 7452
BILL NUMBER: HB 1643

NOTE PREPARED: Jan 4, 2005
BILL AMENDED:

SUBJECT: Health Insurance Claim Filing and Payment.

FIRST AUTHOR: Rep. Ripley
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
DEDICATED
FEDERAL

IMPACT: State

Summary of Legislation: This bill specifies certain requirements for provider submission and payment of claims under state employee health benefit plans, accident and sickness insurance policies, and health maintenance organization contracts. The bill repeals the law requiring use of certain billing codes for health maintenance organization claims filing and payment.

Effective Date: July 1, 2005.

Explanation of State Expenditures: *Requirements for Submission of Claims.* Provisions of the bill could result in a reduction in expenses for an administrator or a health maintenance organization (HMO).

Anthem serves as the administrator of the state's self-insured health plan. Among other provisions, the bill provides that a provider must submit a claim for payment not more than 45 days after the date the claim was incurred. An administrator or HMO must provide an additional 45 days if a provider requests additional time. If a provider submits a claim more than 45 days and less than 55 days after the claim is incurred and has not requested additional time, an administrator or HMO may deduct 1/10 of the cost of the claim from the payment to the provider for every day that the provider fails to submit the claim. If the claim is submitted 55 days after the date the claim is incurred, an administrator or HMO may refuse to pay the claim. An administrator or HMO may also deny a duplicate claim, and a provider that submits a duplicate claim must reimburse the administrator or HMO costs associated with denying the duplicate claim.

An administrator or HMO is allowed time to investigate the legitimacy of a claim. If a provider submits a duplicate claim, a claim that the administrator or HMO is unable to process, or a paper claim, the administrator

or HMO may charge the provider up to $100. An administrator or HMO may terminate a payment agreement if the provider establishes a pattern of failing to submit claims as required. These provisions could reduce costs for an administrator or HMO. It is unknown if the administrator or HMO would pass any reduction in costs on to the state.

Sanctions by the Licensing Authority. A provider must not bill a covered individual for any amount of a claim not paid by the administrator or HMO because the administrator or HMO is relieved of responsibility for payment or permitted to take a deduction from any amount owed. A provider that bills an individual is in violation of the above and is subject to sanctions by the licensing authority. (Licensing authorities could include boards staffed by the Health Professions Bureau, the State Department of Health, or the Department of Mental Health and Addiction.) These provisions could increase administrative expenses for the licensing authorities. It is expected that any additional administrative costs could be absorbed given existing funding and resources.

Reports Required by the DOI Commissioner. The DOI Commissioner may require an insurer to submit reports concerning the insurer's compliance. If reports are required, the Commissioner must prescribe the content, format, and frequency of the reports in consultation with insurers. The Commissioner may not require reports to be submitted more frequently than quarterly. The Commissioner may not use findings from a report submitted as the basis of a finding of a violation. The Commissioner may use information contained in a report to form the basis for conducting an examination of the insurer. During this examination, the Commissioner may examine data collected for the same period as the period covered by the reports, and the Commissioner's examination findings may be used as the basis for a finding of a violation. If the Commissioner finds that an insurer has failed to process and pay clean claims, the Commissioner may assess, with reasonable written notice to the insurer of the basis of the Commissioner's findings, the penalty to be imposed and the opportunity for a hearing. The bill could result in additional administrative expenses for the DOI. However, it is expected that the DOI will be able to absorb any additional expenses given its existing budget and resources.

The bill applies to claims incurred after June 30, 2005.

Explanation of State Revenues: If the Commissioner finds that an insurer has failed to process and pay clean claims, the Commissioner may assess a civil penalty which could range from $10,000 to $200,000. Civil penalties are deposited in the state General Fund.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: DOI.

Local Agencies Affected:

Information Sources:

Fiscal Analyst: Bernadette Bartlett, 317-232-9586.